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EDITORIAL

Editorial

Promoting an Alternative to Traditional Nursing Home Care: Evaluating the Green House Small Home Model. An Introduction from the Funders and the Green House Project

Although the number of nursing home residents has decreased slightly in the last decade and the community is often the preferred setting for those requiring long-term care (AARP Public Policy Institute 2005), the need for skilled residential care remains. Within the field of long-term care, there has been an ongoing interest—known broadly as culture change—in improving the look, feel, and delivery of skilled nursing home care (Centers for Medicaid and Medicare Services 2013). These efforts date back to the 1983 publication of the Consumer Statement of Principles for the Nursing Home Regulatory System by the National Citizen's Coalition for Nursing Home Reform, which was endorsed by 60 organizations (Koren 2010). Over the past decades, numerous programs have sought to create person-centered care where the voices of elders and those who work with them are considered and respected, and the principles of choice, dignity, respect, and purposeful living are valued. These programs exist within traditional nursing homes and also led to the development of more transformative programs, including small home residential models. Still, culture change remains an evolving movement with little evidence to guide providers in implementing changes with proven impact (Shier et al. 2014). As a result, many nursing home providers are eager to learn more about what works to improve care and quality of life.

This special issue of *Health Services Research* is focused on the results of evaluative research on the Green House (GH) small home model of skilled

nursing home care. Conducted by The Research Initiative Valuing Eldercare (THRIVE) collaborative, and funded by the Robert Wood Johnson Foundation (RWJF), this research provides an important step forward in what we know about the process and impact of intense and prescriptive culture change efforts.

The innovative GH model is a radical departure from the traditional skilled nursing home. GH homes are residences for 10–12 elders. Their small size, physical design, and commitment to person-directed care aim to offer privacy, autonomy, and support to elders who want to live their lives in a home environment. Staffing is organized to empower the direct caregivers (known as *Shahbazim* in GH terminology) and elders to be meaningfully engaged, develop personal relationships, and to take ownership of care. While GH homes follow a very specific design and staffing structure, many of their elements are not unique to the model, and so the research presented in this issue has relevance to a broader set of organizations undergoing culture change and striving to improve the experience of residential long-term care.

Since its inception, RWJF has made a series of investments to promote long-term care programs and policies that allow individuals to remain in their homes and communities. Examples of programs that have been designed and replicated include the integration of Medicaid and Medicare financing, the development of supported housing and adult day services for elders, long-term care insurance, and caregiver supports. The Foundation had not previously funded nursing homes, but understood that there was a need to transform nursing home care. However, there was little interest in developing programs that would promote what were viewed as marginal improvements in the delivery of care.

The idea for the GH model came from William H. Thomas, a geriatrician who believed that nursing homes were toxic places to live—sterile organizations where elders were isolated from the community, lacked dignity, and lost their independence and autonomy. In their place, he envisioned small intentional communities that would be designed to foster meaning and development for elders even as they faced increasing disabilities and loss. These communities would not only provide required skilled nursing care but also

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strong, nurturing relationships with staff that would end the loneliness and isolation experienced by residents in institutional nursing homes.

Following lengthy conversations with Dr. Thomas, and assessment of the model's financial feasibility and testing of the concept, staff at RWJF came to see the GH model as a radical innovation that could potentially transform institutional long-term care and how we view and care for frail older adults. In 2002, the Foundation provided a seed grant to pilot test the GH model at Mississippi Methodist Senior Services in Tupelo, Mississippi. Based on the successful implementation of the Tupelo venture, RWJF partnered with NCB Capital Impact (now named Capital Impact Partners) to provide the first of several grants to replicate GH homes across the country and become known as the GH Project. Since the inception of the model, the GH Project has drawn on research to inform its development, dissemination, and implementation. As the model has expanded its reach—with GH homes now in development or operation in 33 states—the GH Project has used research findings to adapt and further develop educational curricula and other tools and resources, addressing implementation challenges as well as amplifying areas of success. The GH Project provides expert guidance, intensive education, and ongoing support to promote successful implementation and sustainability for organizations adopting the model. Tools and resources have been developed in areas of financing, architecture, leadership and team development, regulatory alignment, and project management. The GH Project's objective is to bring stakeholders, regulators, and providers together for vital collaboration, acknowledging mutually shared goals and seeking strategies that bring impactful solutions.

As a leading model of culture change, the GH model has played a significant role in creating new visions for long-term care, driving both practice and policy in aging services. What has been missing is empirical evidence about whether the model can be replicated with fidelity and if these new structures and processes of care lead to any measurable differences, positive or negative, in quality of care or clinical outcomes. While fully understanding the difficulty of identifying appropriate measures of care for this population, RWJF felt it was important to address this gap and therefore in 2010 an evaluation of the GH model was planned.

This evaluation is in keeping with RWJF's long history of funding evaluations of its major initiatives. Results are used to both improve programs and help disseminate effective models. The audiences for program evaluation and research are those currently implementing the program; those interested in implementing the program; policy makers who, if convinced of a program's

benefit, can help remove barriers to implementation or spread; funding agencies that are interested in evidence-based interventions; and researchers who can guide their future investigations accordingly. The GH Project, which promotes and supports adoption of the model across the country, was identified as a good candidate for evaluation having already received a large investment from the RWJF. The GH Project staff was eager to understand the impact of the model on cost and quality, as well as its potential for large-scale spread, and was well placed to communicate these findings to interested policy makers.

Prior studies helped inform the research questions and design of the THRIVE evaluation. An extensive literature review found evidence for a number of the individual culture change elements included in the GH model (Zimmerman and Cohen 2010). Seven of the 11 elements identified by an expert panel showed general support in the literature. These elements include support for the physical environment (such as private rooms and access to the outdoors) and elder-centered care, but more work was clearly needed on the innovative staffing model. Although little evaluative research has been done specifically on the GH model, a study in four GH homes did find some benefits compared to traditional nursing homes, particularly in quality of life and satisfaction of residents and families (Kane et al. 2007). Subsequent work highlighted the variation in the staffing model in GH homes and its relation to care processes and worker stress, indicating that the staffing model needs careful attention (Bowers and Nolet 2014). In addition, model fidelity must be considered when disseminating a model; the GH model must consider how much variability is acceptable and which elements are central, as noted in this issue, when asking how "green" must a GH home be to honor the integrity of the model's core values (Zimmerman et al. 2016).

The RWJF chose to fund a multidisciplinary team of researchers for the evaluation of The GH Project, tapping into deep expertise in long-term care and particular experience in economics, nursing, social work, statistics, health services, and health informatics. Projects were funded separately, which provided a unique level of shared leadership among study investigators. The THRIVE collaborative designed and implemented the research in this special issue as a team, drawing across their expertise to strengthen each study.

The Foundation's overall goals for the evaluation were to provide comprehensive evidence to state and federal policy makers pertaining to the impact of the GH model compared to other models of nursing home care, and inform long-term care organizations, investors, funders, and policy makers seeking to either replicate and sustain the model or use some of the effective

care processes in non-GH nursing homes. In a productive collaboration with GH Project and RWJF staff, the THRIVE team identified the following specific aims and designed an evaluation to address each (Bowers et al. 2013):

- To identify and describe the core elements of the GH model and examine how GH homes implement these core elements initially and over time;
- To identify the characteristics of non-GH nursing homes engaged in significant culture change (i.e., seeking to achieve processes and outcomes that are better aligned with the values and desires of the person receiving care), and to describe the similarities and differences between those nursing homes and GH homes (results presented elsewhere; Elliot et al. 2014);
- To describe and compare the characteristics of staff working in traditional, culture change, and GH nursing homes;
- To identify, describe, and assess the sustainability of clinical care practices and processes associated with better resident outcomes;
- To determine the characteristics of nursing homes that later adopt culture change and the GH model (results presented elsewhere; Grabowski et al. 2014); and
- To evaluate the impact of this model on the costs and quality of care.

The work presented in this special issue of *Health Services Research* builds on papers published in the January 2014 special issue of *The Gerontologist*. The aim of this special issue is to add to the evidence about care and outcomes in high-intensity culture change models, both specific to GH homes and also using GH homes as the model. Some of these studies made comparisons to similar nursing homes and/or to the "legacy home" (the original nursing home that remains open alongside its GH home) and/or to nationally matched nursing homes. Wherever possible, the THRIVE studies nested data from the qualitative work led by Bowers, the quantitative work led by Horn and Zimmerman, and the administrative data analysis work led by Grabowski. In addition, The GH Project staff was a true partner with the research team in defining the research questions and thinking about the relevance of the results (Bowers et al. 2013).

In this special issue, Cohen et al. (2016) describe the core values and essential practices of the GH model and compare select features of GH homes with their legacy units and other nursing homes. Bowers and team look at the sustainability of the GH model and into the "black box" of hospital transfers to explore differences in GH homes that have lower and higher hospital

transfer rates (Bowers et al. 2016a,b). In two papers, Afendulis et al. (2016) examine the impact of GH adoption on nursing home quality and Medicare spending and utilization (Grabowski et al. 2016). Brown and team provide a brief report on workforce characteristics and perceptions of staff in GH homes compared to other nursing homes (Brown et al. 2016); and Bowers et al. (2016a,b) look at the factors that influence the ability of organizations to maintain the prescriptive GH model. Finally, Zimmerman presents a synthesis and critical examination of the evidence related to the GH model of nursing home care (Zimmerman et al. 2016).

The Robert Wood Johnson Foundation is confident that this evaluation of the GH small home model will benefit policy makers, providers, researchers, and other stakeholders who are invested in improving the quality of nursing home care.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.